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UNDER SECRETARY FOR HEALTH'S INFORMATION LETTER

REQUEST FOR PROPOSALS (RFP) TO BECOME A NATIONAL VHA CARE COORDINATION TRAINING CENTER

1. This Request for Proposals (RFP) announces the opportunity for Department of Veterans Affairs (VA) medical centers to submit proposals to become a national Veterans Health Administration (VHA) care coordination training center. The intention of this RFP is to create within 12 months one training center that will train staff in care coordination to care for 17,000 veterans.

2. The purpose of this training center is to provide staff education and training to support the roll-out of a national program of care coordination at the Veterans Integrated Service Network (VISN)-level throughout VHA.

3. Care coordination involves a multi-disciplinary group of health care professionals. The objective of this RFP is to support developing the required curriculum, creating the necessary training resources, and determining the optimum methods to ensure that a multi-disciplinary group of staff have the skills and competencies to offer appropriate, safe, effective, and coherent methods of care coordination to patients.

4. Care coordination programs enhance the care of veterans with chronic disease conditions so that the home can be the preferred place of care. Initial areas of clinical focus for these programs are:

a. Diabetes,

b. Congestive heart failure,

c. Mental health disease,

d. Spinal cord injury,

e. Wound care, and

f. Infectious disease. ***NOTE:*** *Later developments are expected to include the care coordination of oncology care, Alzheimer's disease, and helping patients cope with problems related to restricted activities of daily living (ADLs).*

5. Definitions

a. **Care Coordination.** Care coordination is a process whereby the ongoing condition of selected patients is assessed and monitored using telehealth technologies to pro-actively detect changes in indices that alert to the need for prevention, investigation, and treatment to take place that enhances the health of patients and prevents unnecessary and inappropriate utilization of resources. ***NOTE:*** *Attributes of an Ideal Care Coordination Service are: Mission - To coordinate the right care in the right place at the right time; Vision - The place of residence is the place of care; and Values - Teamwork, caring, advocacy, expertise, commitment, and visionary leadership.* Care Coordination uses best practices that are derived from scientific evidence to bring together health care resources from across the continuum of care in the most appropriate, effective, and efficient manner to care for the patient.

b. **Telehealth Technologies.** Telehealth technologies are information technology-based tools that collect clinical indices in the form of vital signs, disease management data, still images and live video from an originating site where the patient is located. These data are sent via telecommunications networks to a remote site where they are received, reviewed, and assessed by clinicians. Telehealth technologies enable a range of health care services to be provided that cross the usual constraining boundaries of geographic distance, time, and social and/or cultural borders. This range of health care services include, but is not limited to: vital sign monitoring, disease management, wound care, and medication compliance management.

c. **Continuum of Care.** Continuum of care is the coordinated linkage of health care programs and interventions in a way that meets an individual's ongoing needs with the appropriate level and type of medical, psychological, health, or social care resources that have been accessed, as required, from primary, secondary or tertiary care health care sectors.

d. **Continuity of Care.** Continuity of care involves seamlessly passing the responsibility of clinical care of patients between practitioners so that care is delivered in a consistent manner across organizations, over time.

e. **Care Management.** Care management oversees the management of patients who are at risk of deteriorating and who utilize high levels of health care resources. These services include, but are not limited to: assessment, care planning and implementation, education, referral, coordination, advocacy, monitoring, and periodic re-assessment. Together with telehealth technologies and disease management tools these elements form the core basis for care coordination.

6. Background

a. In Fiscal Year (FY) 2002 there were over 6.8 million enrolled veterans of whom 4.5 million received care from the Veterans Health Administration (VHA) at an annual cost of $23.02 billion. The health care needs of the veteran population are higher than the United States (U.S.) average, especially for mental health services. However, utilizing the Centers for Disease Control and Prevention (CDC) ratio, a conservative estimate for the veteran population would indicate that 4 million enrolled veterans have one or more chronic health conditions, with 1.64 million having restrictions in performing activities of daily living (ADLs), and 480,000 unable to live independent

lives. This need is creating a major growth in the demand for VA services, particularly in terms of the requirements for long-term care. This increased demand is creating challenges in providing access to care for veterans and their caregivers using traditional modes of health care delivery.

b. From a population of 4.5 million current veteran patients, a needs assessment in Fiscal Year (FY) 2002 suggested that there are 14,000 to 17,000 patients who can immediately benefit from the models of care coordination that have been developed in VISNs 1, 2, 8, 11, and 17. Those models of care coordination improved the quality of care while simultaneously reducing cost of care in this population sub-set. This group represents 0.4 percent of the VA user population, and is identified by the combination of specific Diagnostic Related Groups (DRGs) and a total individual cost of care received of at least $25,000 per year. DRGs include congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes, mental health disorders, and rehabilitation.

c. Care coordination requires the support of a range of telehealth technologies that include telemonitors, videophones, in-home messaging, disease management tools, computers with Internet chat rooms, and photography. Choosing the appropriate technology means matching it to the patient's needs and its usability. Care Coordinators utilize these technologies to determine patients' clinical needs, health status, and educational requirements. Using Care Coordination together with these commercial off the-shelf (COTS) technologies in accordance with a technology algorithm (contact John Peters at 202-273-8508 for a copy) has resulted in demonstrably improved outcomes in patient care. For example, over 90 percent of patients are satisfied with the technology used and the associated care coordination process. Significant improvements are seen in five of eight domains as measured by the SF-36V (a quality of life assessment tool) for the chronic medical disease population with no perception of any associated deterioration.

d. Implementing this proven model of Care coordination with home-telehealth in a systematized manner achieves levels of patient satisfaction, improved functional status, and resource utilization that indicate this model of care can significantly meet the challenges VHA faces in delivering long-term care to veteran patients.

e. If the projections for care coordination are realized, there will be an ultimate need to provide care coordination to 1.1 million veterans. Proposals will therefore need to consider these short-term, medium-term, and long-term training needs when submitting a proposal. The responsibilities of care coordinator currently apply to nurse practitioners, social workers, dieticians, occupational therapists, or pharmacists. ***NOTE:*** *Applicants for training centers are advised to consider whether the care coordination role is a function that is transferable to multiple staff groups in multiple situations and what will be the probable roles of information technology and health informatics in making this happen.*

7. Funding. Funding of up to $1 million will be made available to the selected training center in FY 2004. This funding may be apportioned in any manner the site deems most suitable in the first year. Thereafter $260,000 per year will be made available for a further 2 years. At the end of this period it is anticipated that the center will become self-sustaining.

8. Rating and Evaluation of Proposals. Proposals will be evaluated and rated for merit, innovation and completeness in response to each of the elements outlined above by an appointed panel of field and VHA Central Office staff. Special emphasis will be given to the following aspects:

a. How the mission and values of the program harmonize with the mission and values of the VHA.

b. The ability to systematically and efficiently train staff in care coordination.

c. Health education, disease management, and addressing the care need of patients, family, and/or significant others as part of this training and education.

d. Focus on staff training in the context of the other clinical care, managerial, and professional duties of staff, including the time devoted to each and how it is prioritized.

e. Address the appropriate balance between academic rigor in a program and providing skills and competencies that translate into meeting the day-to-day care needs of patients.

f. The level of training and education resources that are made available and their ease of access.

g. The innovative use of new technologies.

h. Creating learning communities and offering mentorship.

9. **Timetable for Submission and Funding.** Proposals are to be submitted no later than August 4, 2003. Once all the proposals have been received, the review proceeds for 45 days, followed by funding, as available, to selected program sites. Training is expected to start on, or around, February 1, 2004.

10. Submission. An electronic and ten paper copies of each application are to be submitted to:

Chief Consultant,
The Office of Care Coordination (11T)
Office of Patient Care Services
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

11. General References

a. Extrapolation from figures in CDC. National Diabetes Facts and Figures, 2000. www.cdc.gov.

b. Extrapolation from figures in Robert Wood Johnson Foundation. www.improvingchroniccare.org.

c. The Development and Expansion of Home-Telehealth in VHA: A paper summarizing the discussions and recommendations generated from a 2-day VHA meeting on Home Tele-health. April 2002.

d. VHA Home-Telehealth Toolkit.

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f. Field, M., ed. Institute of Medicine Report- Telemedicine- A Guide to Assessing Telecommunications in Health Care. National Academy Press, 1996.

g. Reid J. A Telemedicine Primer: Understanding the Issues. Innovative Medical Communications, 1996.

h. Kolodner RM, ed. Computerizing Large Integrated Health Networks- The VA Success, Springer, NY. 1997.

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l. Perednia DA, Allen A. "Telemedicine Technology and Clinical Applications," Journal of the American Medical Association (JAMA). 1995; 273:483-488.

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s. Balas EA, Jaffrey F, Kuperman GJ, et.al. "Electronic Communication with Patients-Evaluation of Distance Medicine Technology," JAMA. 1997; 278:152-159.

t. Grigsby J, Sanders JH. "Telemedicine: Where it Is and Where It's Going," Annals of Internal Medicine. 15 July 1998. 129:123-127.

u. Grigsby B, Allen A. "5th Annual Telemedicine Program Survey-Part 1- United States," Telemedicine Today. June 1998:36-37.

v. American Psychiatric Association Resource Document on Telepsychiatry via Videoconferencing, APA Committee on Telemedical Services, 1998.

w. American Psychiatric Association: http://www.psych.org/pract_of_psych/tp_paper.html

x. VHA telemedicine: http://www.va.gov/telemed

y. Telemedicine Information Exchange: http://www.telemed.org

z. Federal Telemedicine Gateway: http://www.tmgateway.org

aa. Telemedicine Activities of National Library of Medicine: http://www.nlm.nih.gov

bb. Department of Defense telemedicine: http://www.matmo.org

cc. American Telemedicine Association: http://www.atmeda.org

dd. Medical College of Georgia telemedicine: http://www.mcg.edu/telemedicine

ee. University of Iowa telemedicine: http://telemed.medicine.uiowa.edu/index.html

ff. University of Vermont telemedicine: http://www.uvm.edu/infoconn

gg. East Carolina University telemedicine: http://www.telemed.med.ecu.edu

hh. Kansas University Medical Center: http://www2.kumc.edu/telemedicine/index.asp

ii. University of Virginia telemedicine: http://www.telemed.virginia.edu

jj. University of Arizona telemedicine: http://www.ahsc.arizona.edu/telemed

12. Requirements. Those interested in responding to this RFP need to review Attachment, A which contains requirements for submitting a proposal.

13. Inquiries. Questions regarding this RFP should be directed to Adam Darkins, M.D., Acting Chief Consultant, The Office of Care Coordination at (303) 393-4645, e-mail: Adam.Darkins@mail.va.gov, or Patricia Ryan, Acting Associate Chief Consultant, The Office of Care Coordination, at (727)-319-1285, e-mail: Patricia.Ryan@med.va.gov or Fax at (202) 273-9126.

Robert H. Roswell, M.D.
Under Secretary for Health

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ATTACHMENT A

REQUIREMENTS

1. **Eligibility Requirements.** To be eligible to apply to be one of the Veterans Health Administration (VHA) national care coordination centers, a site must meet the following requirements:

a. Have an academic affiliate.

b. Establish a collaborating working relationship with the Department of Veterans Affairs (VA)'s Employee Education System (EES).

c. Be in a Veterans Integrated Service Network (VISN) that either is, or is applying to be a care coordination implementation site, i.e., a Fiscal Year (FY) 2003 selectee as a care coordination implementation site or submitting in response to this Request for Proposal.

d. Apply for VHA licensing of the VISN and/or facility care coordination program within 12 months of receiving the training center award and apply to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for certification in disease-specific care within 12 months of the award.

e. Be developing new, or maintaining existing care coordination disease management programs.

f. Work with the existing six VISNs selected to develop the initial curriculum and, further, to develop a standardized curriculum in conjunction with the subsequent training centers.

2. **Elements of Proposal**

a. **Determining a Curriculum.** All prospective program applications must detail how they will create a comprehensive curriculum with which to train care coordinators in needs assessment, clinical care applications, technology usage, business processes, and quality assessment components of a care coordination program including mechanisms for collaborating with subsequent care coordination training centers. In defining these collaborations, centers may specialize in selected areas rather than cover all the chronic disease entities covered by care coordination. Should a center choose this route it must develop a plan for an explicit agreement with another center that covers the rest of the care coordination training requirements. This collaboration must result in common methods of practice that encourage the delivery of one standard of care coordination throughout VHA using standardized technologies and clinical monitoring assessment and referral. It is expected that the curriculum will harmonize with the VHA home-telehealth toolkit, which may be obtained from the Telemedicine Strategic Healthcare Group, VA Central Office, Washington, DC 20420. ***NOTE:*** *Contact John Peters at 202-273-8508.*

b. **Establishing a Suitable Faculty.** Prospective training centers must identify how they will recruit or otherwise gain access to the necessary faculty to train and educate care coordinators using the comprehensive care coordination curriculum they have described above.

c. **Deciding the Mechanism of Delivering Training.** All prospective programs must demonstrate they can implement processes for the comprehensive training of care coordinators in VHA that will meet the short-term, medium-term, and long-term needs of the VHA national care coordination program. They must give timeframes that match the intended VHA care coordination roll-out.

(1) If care coordination is to assist in meeting the health care demands of an aging population with chronic disease, these training needs may develop exponentially and need frequent up-date.

(2) If care coordination is to deliver just-in-time care in a rapidly changing health care environment, it is anticipated that care coordinators would need just-in-time training and education.

d. **Technology Requirements.** New technology in the realms of information systems and telecommunications are revolutionizing the delivery of training and education. If technology is to be used to provide training and education, these resources must be explicitly described and processes whereby interoperability with other centers and the appropriate longevity of equipment assets are ensured. The use of remote and/or distant learning technologies is an anticipated part of the submission.

e. **Employment of Technology.** Prospective training centers are expected to take advantage of appropriate technologies to maximize the delivery of training to staff and minimize the need for travel. How the specification, installation, and maintenance of equipment are undertaken must be described.

f. **Targeting the Groups to Train.** Different approaches may be considered, from didactic training of care coordinators to a train-the-trainer approach. The proposals must make it clear how they expect to target the appropriate recipients of training and ensure they get the appropriate training and education resources delivered to them in the most effective, cost-effective, and stimulating fashion.

g. **Assessment of the Skills and Competencies Needed for Care Coordination.** Prospective training sites must describe in detail how they will assess the skills and competencies that are implicitly and explicitly required for care coordinators to learn in their curriculum. This must include the frequency of these evaluations, how any qualifications are provided and how these are assessed and legitimized with the appropriate departments and/or institutions within, and outside VA.

h. **Physical Space Requirements.** This proposal must consider the adaptation of existing buildings or other physical and/or technology assets to create a suitable training center; it will not provide for the building of such assets.

i. **Travel.** Funds awarded through this RFP will not include funds for the travel of faculty or students.

3. Format for the Proposal

a. Each proposal must begin with an executive summary no longer than two pages. This is to summarize information regarding the proposal and to quantify the staff numbers it expects to train in the short, medium, and long-term.

b. Next, each of the elements described in paragraphs one and two of this attachment, must be addressed. All proposals are to address each element.

c. Proposals must be prepared using standard size paper (8½ x 11), single spaced, with 10 or larger font size. Number each page sequentially and limit the application to fifteen pages in length.

d. Each proposal must be reviewed locally with support indicated in accompanying letters from facility Directors and VISN offices indicating clinical leadership and information management input, and their support for the proposal.

e. Each proposal must have identifying information in the cover letter: the name and address of VA facility submitting proposal, and contact information (name, phone, fax, e-mail, if available) for the clinical staff responsible for preparation and submission of the proposal.